EXHIBIT E

1210 Brace Road, Suite 102
Cherry Hill, NJ 08034
May 25, 2017

Bonjean Law Group
1000 Dean Street, Suite 422
Brooklyn, NY 11238

Re: **Stephen Stadler v. Glenn Abrams, *et al.*** 13-cv-02741

Dear Ms. Bonjean:

At your request, I have prepared a narrative report discussing Mr. Stadler's medical condition prior to and after 3/13/13.

Professional Background

I received my medical training at the University of Pennsylvania Medical School from 1983-1987, graduating with a medical doctor degree. I participated in a three-year residency program in internal medicine from 1987-1990 at which time I was endorsed by the American Board of Internal Medicine as a board-certified internist. My internal medicine board certification has been maintained continuously from 1990 through the present time based on successful completion of a written examinations for the 1990-2000, 2000-2010, and 2010-2020 time periods. "Physicians certified by the American Board of internal medicine demonstrates that they have the knowledge, skills and attitudes essential for excellent patient care[1]."

"Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness[2]."

General internists are trained in the pathophysiology and pathology of adult medicine. The scope of a general internist is quite broad. General internists see patients with a broad array of problems related to the brain, spine, autonomic nervous system and peripheral motor and sensory nervous systems; hematological disorders; bones, joints, tendons, ligaments, and metabolic bone disease; genetic and inherited disorders; pharmacology; psychiatric illness; oral and dental problems; kidneys and genitourinary system; swallowing disorders; esophagus, stomach, small and large intestine, rectum, and anus; head, eyes, ears, nose, and throat; arteries and veins; endocrine diseases including but not limited to diabetes, thyroid disease, pituitary disease, and adrenal disease; high blood pressure; rheumatological and autoimmune diseases; infectious disease; cardiac valvular, conduction system, arterial, and heart muscle; the lungs, pulmonary vasculature, pleura, and chest wall. The internist receives training in

[1] http://www.abim.org/ (American Board of Internal Medicine)
[2] https://www.acponline.org/about-acp/about-internal-medicine (American College of physician)

interpretation of laboratory reports including microbiology, pathology reports, and interpretation of radiographic studies. The internist, serving as a family physician for adults often provides first-line evaluation of problems associated with this wide variety of organ systems; the internist then decides whether to handle these problems primarily or to seek consultation with surgeons and/or non-surgical specialists to provide care in collaboration with these consultants.

Since completion of my internal medicine residency program in 1990, I have worked as a hospital-based physician from 1990-1995 providing care to thousands of hospitalized patients on the general medical and surgical floors, in the intensive care units, and as a consultant providing infectious disease expertise. From 1995 through the present time, I have provided hospital-based care, have seen patients in an outpatient general internal medicine office setting, and have provided care to thousands of patients in acute, subacute, and extended care nursing facilities.

In preparation of my report I have reviewed the following records:

- Amended Complaint and Jury Trial Demand [c]
- Complaints - Warrants
- Photographs of Stephen Stadler
- AtlantiCare Regional Medical Center City Campus [A]
- Atlanta County Justice Facility
- Hunterdon Healthcare/Hunterdon Family Medicine at Cornerstone [H]
- Hunterdon Medical Center [HMC]
- Mid-Jersey Orthopedics

Numbers in brackets refer to Bates stamp page numbers.

On 5/25/17, I interviewed and examined Mr. Stadler at his residence:

Hendricks House
542 NW. Blvd.
Vineland, NJ 08360

Prior to 3/13/13, Mr. Steven Stadler, date of birth 12/30/68, was taking trazodone, Paxil 30 mg daily for depression, and the anxiety medication BuSpar [A].

Mr. Stadler had a history of anxiety and depression and a surgical history of right rotator cuff shoulder surgery on 1/9/13 [315]. Prior to rotator cuff surgery, Mr. Stadler worked as a food server and as a landscaper. In the latter occupation, he was responsible for repetitively lifting 40-50 pound bags of mulch. He walked behind a 36-inch lawnmower. He was vigorous and physically active. He was able to run up and down stairs. He played basketball, football and was able to ride his bicycle 10 miles at a time. He was completely unlimited in all activities of daily living and all recreational

pursuits prior to his rotator cuff injury. He had no lower extremity physical limitations prior to 3/13/13.

The complaint indicates that on 3/13/13, Atlantic City police officers Abrams, Moore, and Devlin assaulted Mr. Stadler, striking and kicking Mr. Stadler until he was rendered unconscious, the beating continuing even after Mr. Stadler was handcuffed. After being rendered unconscious, defendant Devlin released a canine which mauled Mr. Stadler's left thigh. The dog's jaw clamped around Mr. Stadler's left thigh. The dog attempted to drag Mr. Stadler down the street causing abrasions to Mr. Stadler's buttocks.

Photographs of Stephen Stadler evidence contusion above the right eye, and abrasions of the left and right forehead. There is a blackened left eye.

AtlantiCare Regional Medical Center City Campus Emergency Room 3/13/13 – 3/14/13

Mr. Stadler was treated for dog bites, skin lacerations, facial contusions, closed head injury, a leg laceration, and a left black eye. He received tetanus immunization.

Mr. Stadler complained of 8/10 severity left eye pain.

The opiate analgesic fentanyl 100 µg was administered for pain at 11:15 PM.

The antibiotic Ancef 1 g intravenously was administered at 11:55 PM.

The opiate pain reliever Dilaudid 1 mg was given intravenously on 3/14/13 at 12 minutes past midnight.

X-ray of the left femur performed in evaluation of pain after her left thigh trauma showed a laceration but no bone abnormality [324]. Lidocaine was administered for topical anesthesia during repair of a 4 cm irregularly shaped laceration of the left quadriceps. A second 3 cm. irregularly shaped laceration of the left quadriceps also required sutures. A third 1 cm irregularly shaped full thickness laceration of the left quadriceps required suturing.

Mr. Stadler had poor plantar and dorsiflexion and of the left foot.

CT of the head was performed in evaluation of altered mental status. Intracranial structures were normal [323]. CT of the facial bones did not identify fracture. There was a periorbital hematoma. The globes were intact. There was blood in the lower portions of the left orbit [321].

At discharge, prescriptions were given for Percocet for pain relief and for the antibiotic clindamycin.

Atlanta County Justice Facility 3/14/13
Mr. Stadler was evaluated on 3/14/13 and found to have "left thigh with semi-sutured dog bites. Ecchymosis, abrasion to forehead and back, left eye ecchymosis and swelling - marked." There were dry scabs overlying knuckles of both hands.

Mr. Stadler smoked one pack of cigarettes daily. He has a history of intravenous heroin and crack cocaine use. He drank alcohol one case of beer daily.

Atlanta County Justice Facility 3/15/13 10 AM
The physician documented bleeding from a deep laceration of the left thigh. Blood had saturated Mr. Stadler's dressings. Using 1% lidocaine anesthesia, the dogbite wound was cleansed and debrided and the edges re-approximated using proline sutures.

Orthopedic evaluation of the shoulder on 3/20/13 described a "mild setback due to altercation with officers... Requires physical therapy/orthopedic follow-up."

Atlanta County Justice Facility 4/6/13
Mr. Stadler had a subconjunctival hemorrhage of the left eye. He had soft tissue injury of the left quadriceps. Suture material had been removed from the left thigh. There were no signs or symptoms of infection and no bruising of the left thigh.

Atlanta County Justice Facility 4/9/13
Mr. Stadler's abrasions and puncture wounds from dog bites were evaluated. He was cleared to return to the general population. He had started physical therapy to improve ambulation.

Atlanta County Justice Facility 4/11/13
On 4/11/13, Mr. Stadler complained, "my testicles and above them are in serious pain ever since the dog bites."

On 4/15/13, epididymitis was treated with the antibiotic Bactrim.

Ultrasound of the scrotum demonstrated a right hydrocele on 4/19/13.

Local wound care with/without topical antibiotic ointment and a dressing was applied to the left thigh wounds on a daily basis from 3/15/13 – 3/23/13 and from 4/3/13 – 4/13/13. The left thigh wounds had healed by 4/13/13.

Atlanta County Justice Facility 5/17/13
Mr. Stadler's left thigh dog bite wounds were well healed.

Atlanta County Justice Facility 6/25/13
Mr. Stadler was evaluated for pain in the left leg. Physical examination showed scarring from the dog bites. There was left leg pain and numbness. Motrin was prescribed.

Atlanta County Justice Facility 8/7/13
Mr. Stadler complained of ongoing left thigh pain at the site of the dog bites. Motrin was prescribed.

Mr. Stadler told me that his left leg gave out and he slipped in the shower and fell on or about 8/22/13.

AtlantiCare Regional Medical Center 8/22/13 – 8/27/13
On 8/22/13, Mr. Stadler was evaluated after a fall in which she sustained splenic injury with hematoma. He complained of dizziness and loss of consciousness after the fall. He complained of rectal bleeding. Hemoglobin was 8.4. INR was elevated at 1.9. Blood urea nitrogen and creatinine were 13 and 1.0. Platelet count was low at 67. Mr. Stadler underwent splenic and mesenteric artery angiography. He carried the diagnosis of hepatitis C with cirrhosis of the liver and a history of gastrointestinal bleeding. He required intubation and mechanical ventilation. Mr. Stadler was treated for hemorrhagic shock after splenic laceration. Mr. Stadler received two units of blood, platelets, and two units of fresh frozen plasma.

Mr. Stadler told me that he has been treated with interferon for hepatitis C, initially with success, but now in relapse. Treatment with oral hepatitis C medication is planned.

Esophagogastroduodenoscopy showed esophageal and gastroesophageal varices and gastric erythema.

Mr. Stadler was treated for a localized abscess on the left forearm.

Blood urea nitrogen and creatinine were 12 and 0.6. Albumin was low at 2.7. Pre-albumin was low at 8.0. Urine drug screen showed opiates. Hemoglobin at the time of discharge was 10.2 after transfusion, up from a nadir of 7.3 on 8/24/13.

Atlanta County Justice Facility

On 9/6/13, Mr. Stadler complained of pain in the left thigh, numbness of the left thigh, and the left leg giving out on him when he walked.

The cardiac ECHO 9/11/13 showed an ejection fraction of 55%.

Hunterdon Medical Center 8/13/15
Mr. Stadler was treated for a staphylococcal abscess of the right index finger, ultimately requiring amputation at the level of the distal interphalangeal joint [H72, HMC4].

Hunterdon Healthcare/Hunterdon Family Medicine at Cornerstone [H]

On 9/15/15, Mr. Stadler described chronic left leg numbness altered gait since his arrest by police and left thigh bite by a police dog in 2013 requiring increased weight bearing on the right knee. Mr. Stadler complained of right knee pain. Examination disclosed to healed but scarred over puncture wounds of the left thigh. The right knee was slightly painful to palpation on both the medial and lateral surfaces but was without swelling. There was pronounced crepitus on range of motion [15]. Dr. Mui felt that right knee pain "is likely from overuse due to past injury [16]." Dr. Mui described numbness in the left thigh "from nerve damage related to the prior traumatic events [16]."

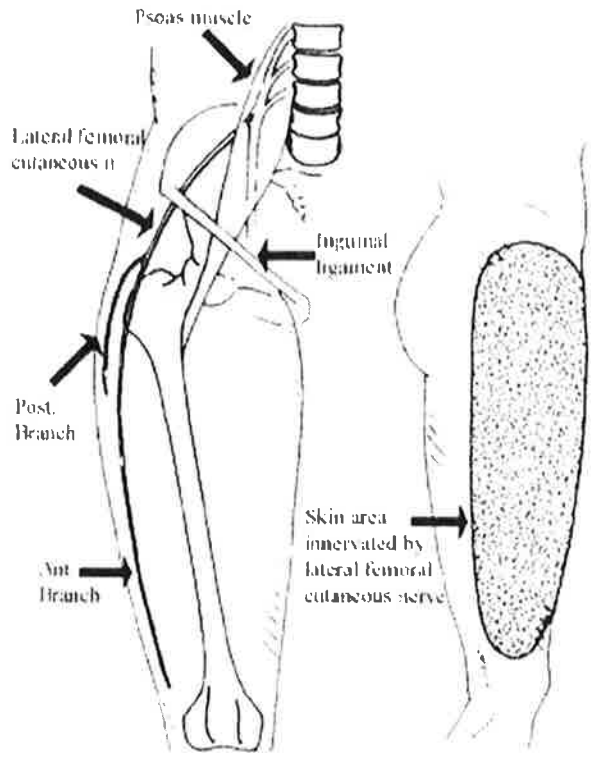
Mr. Stadler complained of worsening pain and numbness in the left thigh. Left thigh pain was progressively worse since 2013. Walking increased pain. He complained of bilateral knee pain. Physical dissemination demonstrated bilateral knee crepitus [34-36].

On 10/26/15, Mr. Stadler was evaluated at Hunterdon Medical Center for the sudden onset of 8/10 severity pressure like left knee and thigh pain. He complained of right knee pain since September 2013, 7/10 severity. Mr. Stadler was working as a food server [HMC18]. Mr. Stadler was diagnosed with mild bilateral knee osteoarthritis [HMC20]. Mr. Stadler described two years of left knee pain to orthopedist Dr. Glassner on 10/26/15 [HMC21]. Dr. Glassner postulated that Mr. Stadler had had an injury to the lateral femoral cutaneous nerve and recommended neurological evaluation for possible nerve conduction velocity/EMG testing. The lateral femoral cutaneous nerve is a purely sensory nerve supplying sensation to the anterolateral thigh.

The lateral femoral cutaneous nerve's course and area of innervation are demonstrated in the diagram below[3]:

3

https://www.google.com/search?q=lateral+femoral+cutaneous+nerve&espv=2&biw=1600&bih=770&source=lnms&tbm=isch&sa=X&ved=0ahUKEwiRq_-XmvvQAhVX2mMKHeChDFYQ_AUIBigB#imgrc=BIrwNCJ4x6sQbM%3A



Mr. Stadler was evaluated on 11/19/15 for left thigh pain since being bitten by a police dog and 2013 [H28]. He was referred for EMG study to neurologist Dr. Viradia [H32].

On 11/30/15, neurologist Dr. Viradia evaluated Mr. Stadler for left knee and thigh pain since 3/13/13. Any movement triggered left thigh pain. Mr. Stadler complained of numbness in the left anterior hip to left knee area. Full extension of the left leg while leaning backward and standing provided temporary relief of left thigh pain [HMC24]. Residual scarring on the left anteromedial thigh was present [HMC25]. Dr. Viradia felt that Mr. Stadler had meralgia paresthetica with left thigh numbness and left femoral nerve injury/left femoral neuropathy with left quadriceps weakness [HMC26]. EMG and nerve conduction studies performed 11/30/15 showed chronic left femoral neuropathy [[HMC 27-29].

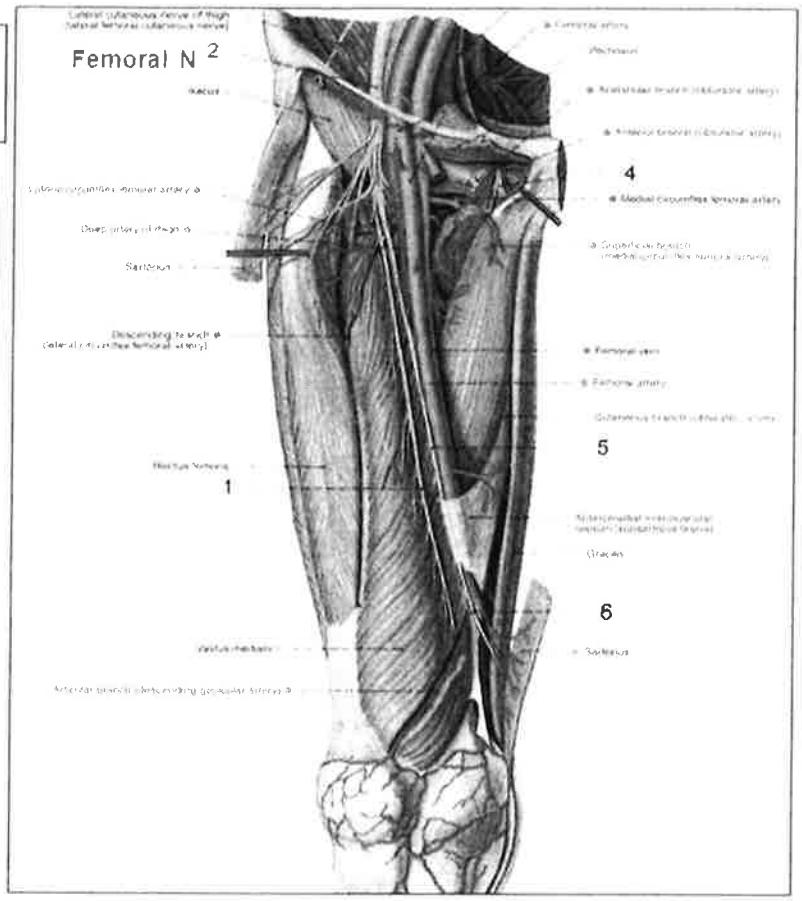
The left femoral nerve is both a sensory and motor nerve. The left femoral nerve is responsible for sensation over the front and medial sides of the thigh, shin, an arch of the foot. Muscles innervated of the posterior branch of the femoral nerve supply the quadriceps muscles which extend the knee. The anatomy of the left femoral nerve is depicted below[4]

4

https://www.google.com/search?q=femoral+nerve&espv=2&biw=1600&bih=770&tbm=isch&tbo=u&source=univ&sa=X&ved=0ahUKEwjnvKf0m_vQAhUB0GMKHTliCo0QsAQIKw&dpr=1#imgrc=8a9qc-2afE0LCM%3A

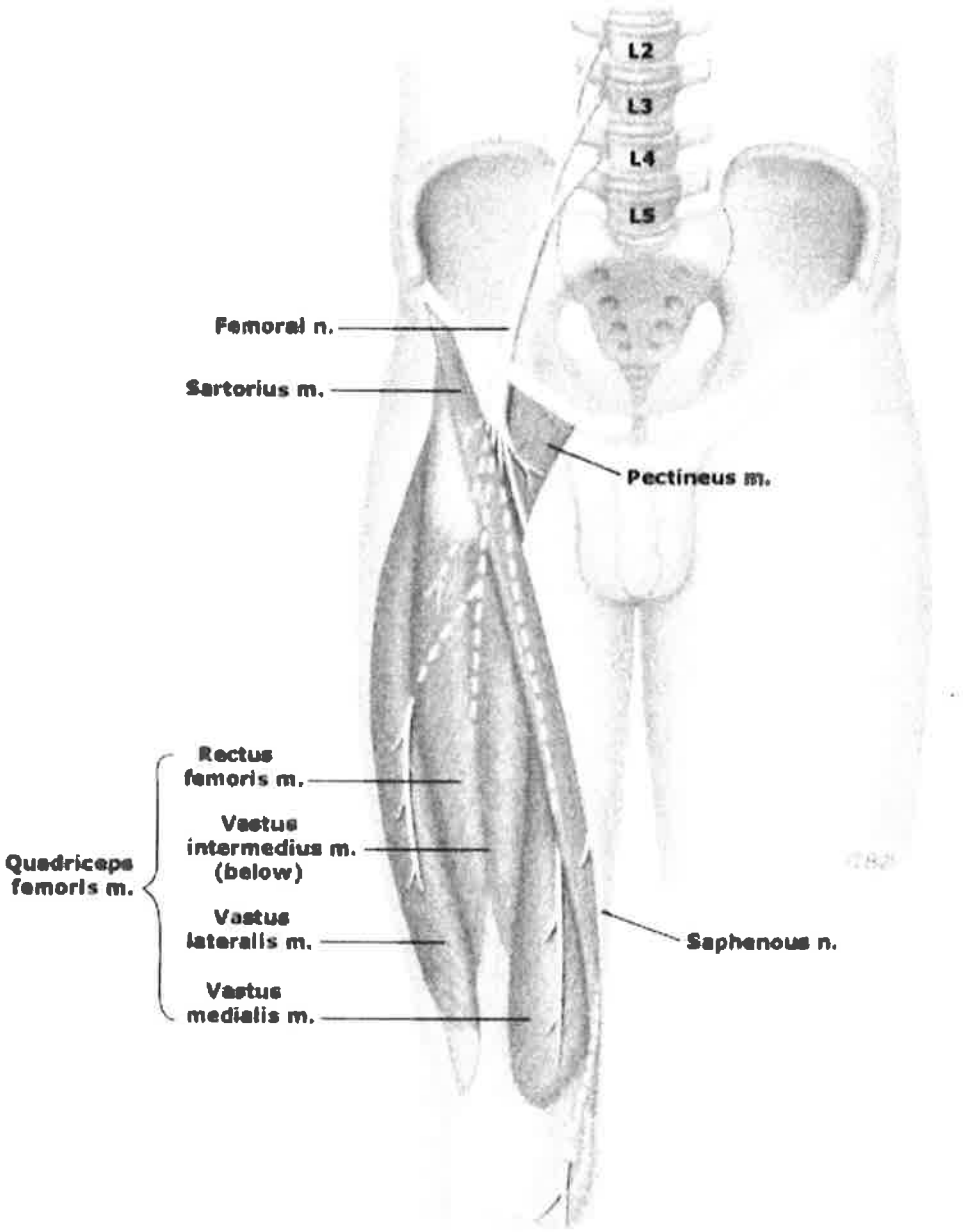
FEMORAL NERVE

- **Origin:**
- From lumbar plexus (L2,3,4).
- Course:
- Descends lateral to psoas major & enters the thigh behind the midpoint of the inguinal ligament.
- Passes lateral to femoral artery, then divides into anterior & posterior divisions.



The anatomy of the femoral nerve depicting course of the nerve and muscles supplied by the femoral nerve is depicted below[5]:

[5] http://cursoenarm.net/UPTODATE/contents/mobipreview.htm?7/19/7477



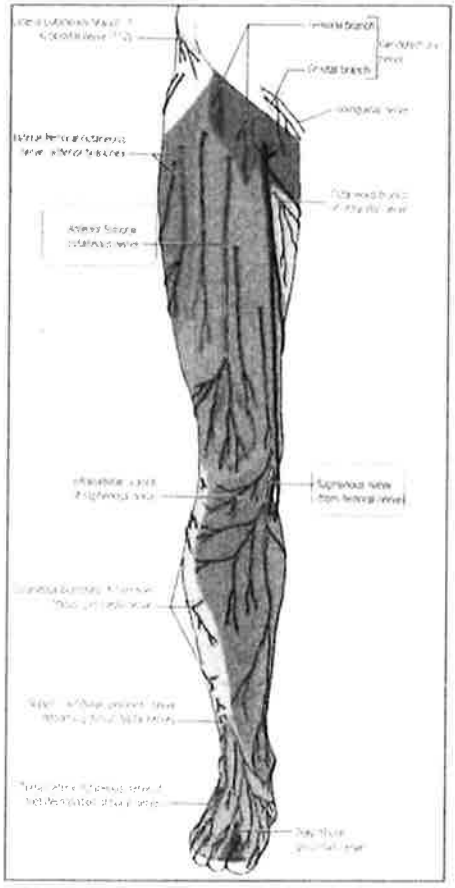
Sensory function of the femoral nerve is depicted in the picture below[6]:

6

https://www.google.com/search?q=femoral+nerve&espv=2&biw=1600&bih=770&tbm=isch&tbo=u&source=univ&sa=X&ved=0ahUKEwjnvKf0m_vQAhUB0GMKHTliCo0QsAQIKw&dpr=1#imgrc=oZEj8ewQ0eC-kM%3A

CUTANEOUS BRANCHES OF FEMORAL NERVE

- To antero-medial aspect of the thigh.
- To medial side of:
- Knee,
- Leg and
- Foot (saphenous nerve).



On 1/18/16, Mr. Stadler was treated for left heel pain and erectile dysfunction [H19].

On 2/17/16, Mr. Stadler was evaluated for left leg pain. He was determined to have lumbar disc degeneration, lumbar osteoarthritis, and lumbosacral radiculopathy for which a course of physical and occupational therapy and analgesic medication was recommended [HMC54]. On 2/23/16, straight leg raising test on the left produced pain down the entire left leg [HMC63].

Mr. Stadler was evaluated on 5/3/16. Medications included Flexeril, Motrin, Naprosyn, Percocet, and prednisone. His problem list included insomnia, cocaine dependence, opioid dependence, panic disorder without agoraphobia, status post right second finger injury in 2015 with resultant infection and amputation, osteomyelitis, hepatitis C, alcoholism, hernia repair, and a **chronic left thigh scar and left leg pain and numbness after being bitten by a police dog 2013** [H6].

On 5/25/17, Mr. Stadler complained of low back pain with standing for prolonged periods of time. He complained of numbness of the medial, anterolateral, and lateral thigh extending from the level of the knee to the upper thigh. Mr. Stadler complains of an ice pick type pain in the left thigh. Pain occurs in the anterior and upper medial thigh

and behind his knee. When he sits for long time, the pain worsens. The pain extends from thigh to knee. With prolonged standing, left thigh pain worsens and he needs to rest for 5-10 minutes every two hours. His current job entails dispensing uniforms to workers and enforcing cleanliness restrictions in a meat factory. He sits at work. Discomfort and a sensation of left leg giving way increase in cold, damp weather. Mr. Stadler complains of walking with a limp. He must ascend and descend stairs slowly.

Mr. Stadler is able to ride a bicycle but only for 1 mile at a time. When he walks, he develops increased pain in the left leg. When he goes to an amusement park, he has to rest periodically. This requirement for rest was not present prior to 3/13/13. Mr. Stadler is no longer able to play full court basketball for longer than 15 minutes because he develops pain and weakness in the left leg with spinning, pivoting, and running. Prior to the 3/13/13 accident, Mr. Stadler played full-court basketball for up to 1 1/2 hours.

On physical examination, Mr. Stadler is a well-developed overweight man in no acute distress. Head, ears, eyes, nose, throat cardiopulmonary, and abdominal examinations are notable only for mild abdominal obesity.

The straight leg raise test is negative in the seated and supine positions bilaterally.

The skin surface evidences three scars on the left medial upper thigh. These are horizontally oriented. The topmost scar measures 3 cm in length. The middle score measures 3 cm in length. The lower scar measures 1 cm in length. There two are additional smaller tooth mark scars on the lateral and left posterior thigh.

Mr. Stadler has a sensory deficit/numbness in the distribution of the lateral femoral cutaneous nerve overlying the anterior and lateral thigh extending from the knee to the upper thigh. Mr. Stadler has a sensory deficit/numbness in the distribution of the cutaneous branches of the femoral nerve. Specifically, he has numbness in his left anterior medial thigh and the medial side of the knee.

On strength testing, there is 4/5 strength of the left quadriceps mechanism. The standard grading system for muscle strength is reproduced below.

Grading Motor Strength

Grade	Description
0/5	No muscle movement
1/5	Visible muscle movement, but no movement at the joint
2/5	Movement at the joint, but not against gravity
3/5	Movement against gravity, but not against added resistance
4/5	Movement against resistance, but less than normal

5/5	Normal strength

Functionally, quadriceps weakness translates into difficulty climbing and descending stairs. Mr. Stadler walks with a limp.

Injuries directly caused by injuries sustained in the 3/13/13 incident:

- Lacerations/puncture wounds/crush injury resulting in scarring of the left medial upper thigh and lateral/posterior thigh.
- Decreased sensation/numbness/pain of the anterior and lateral thigh extending from the upper thigh caused by crush injury to the lateral femoral cutaneous nerve
- Decreased sensation/numbness/pain of the left anterior medial thigh and medial side of the knee caused by crush injury to the cutaneous branches of the femoral nerve
- Quadriceps weakness caused by injury to the motor fibers of the femoral nerve[7].

Treatment required for dog bite injuries sustained in the 3/13/13 incident:

- Lidocaine was administered for topical anesthesia during repair of a 4 cm irregularly shaped laceration of the left quadriceps. A second 3 cm. irregularly shaped laceration of the left quadriceps also required sutures. A third 1 cm irregularly shaped full thickness laceration of the left quadriceps required suturing.
- 3/15/13 Using 1% lidocaine anesthesia, the dog bite wound was cleansed and debrided and the edges re-approximated using proline sutures
- Local wound care with/without topical antibiotic ointment and a dressing was applied to the left thigh wounds on a daily basis from 3/15/13 – 3/23/13 and from 4/3/13 – 4/13/13. The left thigh wounds had healed by 4/13/13

Injuries indirectly caused by injuries sustained in the 3/13/13 incident

- Mr. Stadler fell in the shower when his left leg gave out in August 2013. He sustained a splenic laceration, develop hemorrhagic shock, and required hospitalization, intubation, mechanical ventilation, and transfusion of packed red blood cells.

Permanency

- Quadriceps weakness is permanent.
- Sensory deficits and pain of the left thigh from knee to mid/upper thigh are permanent.
- Scarring as described above is permanent

Future Considerations

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[7] femoral neuropathy was Kim's firm on EMG and nerve conduction testing performed 11/30/15.

With the passage of time, Mr. Stadler will experience age-related decrements in muscle strength. Since he already has strength deficit in the left quadriceps, this will become increasingly debilitating over time as his right leg becomes less and less able to compensate for the left quadriceps strength deficit.

Other considerations

Mr. Stadler has a history of lumbar disc degeneration. Straight leg raise testing in the supine and seated positions was negative on 5/25/17. Mr. Stadler does not provide a history compatible with lumbar spinal stenosis. Accordingly, lumbar radiculopathy/spinal stenosis is not playing any role in his left quadriceps strength deficit.

My opinions are stated within a reasonable degree of medical certainty/probability.

I reserve the right to amend my opinions as further information becomes available.

Yours truly,

John Kirby, M.D.